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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JESSIE V. WALKER** **1202 Glenn Drive** **Euless, Texas 76039** **Registered Nurse License No. 505736** Respondent.	Case No. 2008-184 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing.

2. On October 21, 1994, the Board of Registered Nursing issued Registered Nurse License No. 505736 to JESSIE WALKER. The License will expire on August 31, 2008, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive licence for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny any application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Section 2762(e) of the Code provides, in pertinent part, that it is unprofessional conduct to falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

8. Section 125.3 of the Code provides, in pertinent part, that the Board of Registered Nursing may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a highly potent opiate analgesic drug used to treat moderate to severe pain.

10. "Roxanol" is a trade name for "morphine sulfate", and is a Schedule II controlled substance, as designated by Health and Safety Code section 11055(b)(1)(M), and a

dangerous drug pursuant to Business and Professions Code section 4022. It is a highly potent opiate analgesic drug used to treat moderate to severe pain.

FIRST CAUSE FOR DISCIPLINE

(Grossly Incorrect or Grossly Inconsistent Entries)

11. Respondent is subject to disciplinary action under Code section 2761(a) on the grounds of unprofessional conduct, as defined in Code section 2762(e), in that on or about January and February, 2003, while employed as a registered nurse at Roberts Nursing Home, in Napa, California, she admittedly made grossly incorrect, or grossly inconsistent entries in hospital and patient records pertaining to controlled substances and/or dangerous drugs in the following respects:

a. **Patient S.H.**[1] was a hospice patient, with diagnoses that included dementia, debility and decline, and osteoarthritis. The doctor's orders were to administer Roxanol, as needed, for pain. Respondent engaged in the following conduct in regards to the above-referenced patient:

(1) On February 1, 2003, at 0940 hours, and at 1530 hours, respondent signed out .05 mg of morphine for patient S.H., and failed to chart the administration of the morphine in the patient's medication record or nurses notes.

(2) On February 2, 2003, at 0710 hours, and at 1430 hours, respondent signed out .05 mg of morphine for patient S.H., and failed to chart the administration of the morphine in the patient's medication record or nurses notes.

b. **Patient A.S.** was an eighty-year-old hospice patient, with diagnoses that included Alzheimer's dementia, debility and decline. The doctor's orders were to administer Roxanol, as needed, for pain. Respondent engaged in the following conduct in regards to the above-referenced patient:

(1) On January 12, 2003, at 1400 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol

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1. In order to protect the patients' privacy, their full names will only be released to respondent pursuant to a request for discovery.

in the patient's medication record or nurses notes.

(2) On January 15, 2003, at 0915 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nurses notes.

(3) On January 16, 2003, at 1900 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(4) On January 18, 2003, at 1200 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(5) On January 21, 2003, at 0900 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(6) On January 22, 2003, at 0930 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(7) On January 23, 2003 at 2000 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(8) On January 25, 2003, at 0900 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(9) On January 26, 2003, at 0900 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(10) On January 27, 2003, at 0900 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(11) On January 29, 2003, at 0900 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(12) On February 1, 2003, at 1300 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

(13) On February 2, 2003, at 1000 hours, respondent signed out .05 mg of Roxanol for patient A.S., and failed to chart the administration of the Roxanol in the patient's medication record or nursing notes.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent has subjected her license to discipline pursuant to Business and Professions Code section 2761(a)(1) on the grounds of unprofessional conduct (gross negligence), based on the conduct set forth in paragraph 11, above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Respondent is subject to disciplinary action under Code section 2761(a), on the grounds of general unprofessional conduct, in that on or about May 31, 2003, and/or June 1, 2003, respondent, while employed as a registered nurse at Roberts Nursing Home in Napa, California, reported to work and commenced patient care, while acting erratically and in an impaired mental condition. Respondent admitted to said conduct, which she explained as a "severe manic episode". Respondent further admitted that she was bipolar and suffering from depression and that she had not taken her medication for several months prior to the above incident. Respondent's conduct, as set forth above, reflects upon her fitness to practice registered nursing.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 505736 issued to JESSIE WALKER;

2. Ordering JESSIE WALKER to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/7/07

Dl. L Hochberg for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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